Avant
By doctors for doctors

Avant Mutual Group Limited
ABN 58 123 154 898

Avant Submission to the Scope of Practice Review – Phase 1 survey

About you

Q. Which of the following perspectives best describes your interest in the Scope of Practice Review?

Other – Medical indemnity insurer

Q. What is your postcode?

2000

Benefits of expanded scope of practice

Q. Who can benefit from health professionals working to their full scope of practice?

Consumers, Funders, Health practitioners, Government/s, Other

Other – Organisations that engage or employ health practitioners

Q. How can these groups benefit? Please provide references and links to any literature or other evidence.

Avant believes that a strong and well-supported primary care sector led by general practice will improve health outcomes for all Australians, especially for those with complex chronic conditions (Avant, 2023). This includes those health practitioners identified for consideration by this review and those who support health practitioners in the primary care workforce.

Increasing team-based care led by GPs will enable a better utilised healthcare workforce while preserving the benefits of continuity of care, care coordination and holistic knowledge which are the core skills of GPs (RACGP, 2019).

Allowing health practitioners in GP-led multidisciplinary teams to work their full scope of practice with appropriate accountabilities and safeguards, including clear professional indemnity arrangements, can boost the benefits of team-based care.

We believe that GPs and other primary care health practitioners should be able to work to their full scope of practice, particularly in multidisciplinary teams (MDTs). GPs and other health practitioners should also be able to work to an expanded scope of practice, so long as the practitioner has adequate training and evaluation to ensure competence and patient safety, and there are appropriate accountabilities and safeguards for communication, coordination and continuity of care with regular care providers.

Based on our extensive experience, the main ways in which groups can benefit from health practitioners working to their full scope of practice are:

- Patients benefit from better access to safe, high-quality and more targeted care with less duplication and fragmentation through a more collaborative, flexible and productive workforce.
- All health practitioners are more productive, more satisfied and at less risk of burnout, and better placed to provide safe, high-quality and more targeted care themselves and when collaborating with others.
- GPs have more time to help patients with more complex needs or preventive care, in coordination with other health practitioners who are able to help patients with less complex care needs.
- Organisations that engage or employ health practitioners have a more flexible and more productive workforce and are more efficient because of better coordination and continuity of care.
- Funders and governments receive a greater return on investment through reduced duplication of care and improved health outcomes.

Importantly, realising these benefits will require sensible, phased and harmonised reform so that risks and barriers can be addressed, and change enabled without unintended consequences.

References

Avant Mutual. Avant's position on primary care reform (2023). https://www.avant.org.au/primary-healthcare-reform/
The Royal Australian College of General Practitioners. Vision for General Practice and a Sustainable Health System (2019). https://www.racgp.org.au/getattachment/e8ad4284-34d3-48ca-825e-45d58b2d49da/The-Vision-for-general-practice.aspx

Risks and challenges

Q. What are the risks and other impacts of health practitioners working to their full scope or expanded scope of practice? Please give examples of your own experience.

To discuss the risks and other impacts of working to full scope or expanded scope of practice, we need to acknowledge that scope of practice for Australian health practitioners is dynamic.

While the phrase "scope of practice" is widely used, there is no shared definition or standard that applies across professions. Different health professions and specialities, including general practice, have their own descriptions and models for scope of practice (MBA, 2020) (RACGP, 2023). These can cover both clinical and non-clinical practice (ACSQHC, 2015) (MBA, 2023).

Common criteria used to define scope of practice highlight why it is dynamic within and across health professions. These common criteria for scope of practice are:

- professional competence requirements (e.g., education, training, demonstrated competence in clinical and/or non-clinical practice, registration standards)

- workplace safeguards and settings for the individual practitioner (e.g., positions of employment, clinical protocols, and guidelines) and
- laws, licensing requirements and regulations that apply in each jurisdiction (federal, state and territory).

Further, several terms are frequently used when discussing scope of practice with no consistent or clear definitions. These include "full scope of practice", "top of scope of practice", and "expanded" or "increased scope of practice". For clarity, for our response we have defined these aspects as follows:

- Full scope of practice – working to full scope of practice means that a health practitioner is able to work to the full extent of their profession or specialty's recognised skill base and/or regulatory guidelines. This covers what all practitioners in a profession or specialty can do.
- Top of scope of practice – working at top of scope refers to the value a health practitioner provides over and above what others in the same profession or specialty field can do within their full scope of practice. Systemic and other barriers may prevent a practitioner from working at top of scope.
- Expanded or increased scope of practice – expanded or increased scope of practice requires additional training and evaluation before being performed by a health practitioner. This may include expansion into specific interest areas.

Insurer's perspective

At Avant, we regularly assess the risk of sectors of medical practice, the individual practitioner, and their claims experience to ensure our policy conditions reflect the risk of future claims and complaints. Our focus is to make sure that the practitioners we insure have appropriate indemnity to cover the care they provide to patients.

Our starting point is our Category of practice guide, which currently recognises 80 different categories of medical practice across nine core groups including general practice (Avant Insurance, 2022). We also consider that, with advancements in medicine, practitioners are increasingly working across multiple areas of practice.

As a medical indemnity insurer, the dynamic nature of scope of practice and working to full scope or expanded scope of practice presents one of the greatest risks and challenges.

We seek to manage this risk through our regular risk assessments and working with our members to understand their circumstances. We provide advice and education services that promote safe, high-quality and professional medical practice. In addition, we seek to work with governments and regulators so that professional indemnity arrangements are clear.

Key risks and challenges

The key risks and challenges we see of general practitioners working to their full scope or expanded scope of practice in primary care (including in MDTs) are:

- clear indemnity arrangements and cover for the care they provide to patients when working to full scope or expanded scope of practice so there are no gaps in cover

and both practitioners and patients have confidence that indemnity issues can be appropriately addressed should they arise

- clear accountabilities and safeguards, including professional indemnity arrangements, when coordinating care with other health practitioners so that safe high-quality care is maintained
- funding arrangements that support working to full scope or expanded scope of practice and coordinating care with other health practitioners
- education and training that support practitioner awareness and interprofessional supervision of working to full scope or expanded scope of practice
- heightened risk to patient safety of expanded scope of practice without adequate training and evaluation or appropriate systems, protocols and infrastructure to enable integration with regular care providers including GPs
- significant administrative and compliance burden to working to full scope of practice today which takes the practitioner away from caring for patients.

References

Australian Commission on Safety and Quality in Health Care. Credentialing health practitioners and defining their scope of clinical practice: A guide for managers and practitioners (December 2015) https://www.safetyandquality.gov.au/sites/default/files/migrated/Credentialing-health-practitioners-and-defining-their-scope-of-clinical-practice-A-guide-for-managers-and-practitioners-December-2015.pdf

Avant Insurance Limited. Category of Practice Guide (January 2022). https://avant.org.au/WorkArea/DownloadAsset.aspx?id=25769805131

Medical Board of Australia. Good medical practice: a code of conduct for doctors in Australia (October 2020). https://www.medicalboard.gov.au/codes-guidelines-policies/code-of-conduct.aspx

Medical Board of Australia. FAQ: Recency of practice. Scope of practice and changing jobs (9 May 2023). https://www.medicalboard.gov.au/codes-guidelines-policies/faq/faq-recency-of-practice.aspx#

The Royal Australian College of General Practitioners. Standards for general practice, 5th edition (February 2023). https://www.racgp.org.au/getattachment/ece472a7-9a15-4441-b8e5-be892d4ffd77/Standards-for-general-practices-5th-edition.aspx

Q. Please give any evidence (literature references and links) you are aware of that supports your views.

For this submission we have consulted with Avant's medical practitioner network to understand the GP experience of working to full scope and expanded scope of practice in primary care. We have also drawn on feedback from Avant's GP membership and our own experience assisting and advising medical practitioners over many years. Our anecdotal evidence is that:

- GPs recognise that increasing their scope of practice e.g., by combining general practice with a special interest in a niche area, may increase their risk profile and indemnity insurance premiums. Fear of litigation and complaints also leads some GPs to stop providing some forms of care e.g., care plans or iron infusions, rather than upskilling themselves to work to their full scope of practice.

- GPs recognise that working to full scope or expanded scope of practice still requires clear and appropriate accountabilities and safeguards to ensure safe high-quality patient care. They acknowledge that even when a GP is the coordinator or leader of the team, they will not have a view of what occurs in every episode of care provided by others in the team.
- Systemic flaws in funding arrangements under the Medicare Benefits Schedule (MBS) are discouraging or preventing GPs from working to full scope of practice and delegating and collaborating between health practitioners and in multidisciplinary primary care teams.
- There is a significant compliance and administrative burden to working to full scope of practice today. This is in addition to the demanding requirements of daily patient consultations and care coordination as complex chronic conditions increase.

In addition, Avant has recognised that there is a heightened risk to patient safety of expanded scope of practice without adequate training and evaluation or appropriate systems, protocols, or infrastructure to enable integration with regular care providers including GPs.

- The risk of working to expanded scope of practice without adequate training and evaluation is exemplified by doctors with minimal or no training in the scope performing cosmetic surgery (Ahpra & MBA, 2022).
- The risk of working to expanded scope of practice without appropriate integration with regular care providers is demonstrated by errors involving patient medical discharge information leading to patient harm (Marjot et al., 2021) (CCQ, 2023).

Further, similar risks arise if it is contemplated that new types of providers (e.g., physician assistants and allied healthcare assistants) be introduced to overcome potential workforce shortages. These providers would need to have clear accountabilities and be subject to the same regulatory requirements as other registered health practitioners.

References

Ahpra and Medical Board of Australia. Independent review of the regulation of medical practitioners who perform cosmetic surgery (August 2022).
https://www.ahpra.gov.au/resources/cosmetic-surgery-hub/cosmetic-surgery-review.aspx
Marjot J, Haysom G, Browne P. Medico-legal risks associated with fragmented care in general practice (6 September 2021). Medical Journal of Australia. doi: 10.5694/mja2.51205
Coroners Court of Queensland. Non-inquest findings into the dealh of Elaine Lillian Redmond (26 July 2023).
https://www.courts.qld.gov.au/__data/assets/pdf_file/0004/773653/redmond-elaine.pdf

Real life examples

Can you identify best practice examples of health practitioners working to their full or expanded scope of practice in multidisciplinary teams in primary care?

- No
- Yes

Yes

Please give examples, and any evidence (literature references and links) to support your example.

Through consultation with Avant's medical practitioner network and drawing on our own experience, we have identified the following best practice examples of health practitioners working to full scope and expanded scope of practice in MDTs in primary care:

- *GPs with admitting rights in hospitals.* A clear example of GPs working to their full scope of practice and at top of scope is GPs with admitting rights in hospitals. GPs can successfully manage inpatient treatment of uncomplicated cases e.g., community acquired pneumonia, cellulitis, or pyelonephritis, with non-GP specialists available to provide advice or take over care if necessary. Clear pathways of communication are essential, e.g., with the retrieval services when patients in regional/rural hospitals either need a transfer or some other input from appropriate specialists (Queensland Government, 2023).
- *GPs expanded scope in action.* There are several examples where GPs already expand their scope of practice through education and training to fill service gaps and unmet community needs. In all the following examples, training is provided by those already proficient in the scope (generally non-GP specialists), there are set curricula and assessments, they are not short courses, and the training consolidates and expands the knowledge that medical practitioners already possess to a level where they can fulfil roles in expanded scopes.
    - Rural GPs performing endoscopies and colonoscopies (Queensland Government, 2016)
    - The Royal Australian College of General Practitioners' Rural Generalist Fellowship (RACGP, 2023)
    - Australasian College for Emergency Medicine's training for non-ED trainees (ACEM, 2023)
- *COVID vaccination program expanded scope in action.* The experience of the COVID vaccination program where medical students, pharmacists, and physiotherapists performed vaccinations demonstrated that expanding the scope of these practitioners was a reasonable approach to improve access and program reach (Wiggins et al., 2022).

<u>References</u>

Australasian College for Emergency Medicine. Certificate and Diploma Programs (2023). https://acem.org.au/Content-Sources/Certificate-and-Diploma-Programs
Queensland Government. Children's Health Queensland Retrieval Service (2023). https://www.childrens.health.qld.gov.au/service-chq-retrieval/
Queensland Government. Metro South Health. Princess Alexandra Hospital training Rural Endoscopists (23 September 2016). https://metrosouth.health.qld.gov.au/news/princess-alexandra-hospital-training-rural-endoscopists
The Royal Australian College of General Practitioners. Rural Generalists Fellowship (2023). https://www.racgp.org.au/the-racgp/faculties/rural/rural-generalist-fellowship/about-the-rural-generalist-fellowship
Wiggins D, Downie A, Engel R M & Brown B T. Factors that influence scope of practice of the five largest health care professions in Australia: a scoping review. Human Resources Health 20, 87 (2022). https://doi.org/10.1186/s12960-022-00783-4

Facilitating best practice

Q. What barriers can government, employers and regulators address to enable health practitioners to work to their full scope of practice? Please provide references and links to any literature or other evidence.

Through consultation with Avant's medical practitioner network and drawing on our own experience assisting and advising medical practitioners over many years, we have identified multiple barriers which could be addressed to enable GPs to work to their full scope of practice as GPs and in MDTs.

Technology

- *Interoperability of software and medical records systems.* Lack of interoperability of software and medical records systems prevents communication and coordination between health practitioners and increases the administrative burden as well as the of risk of incomplete information and duplication, particularly where several members of the treatment team are using different systems e.g., the residential aged care facility, the pharmacist, the GP.

Education and training

- *Differing views on requirements to perform tasks.* Differing views among health practitioners about the competence, skills or training required to perform tasks is a barrier to supporting health practitioners to work to full scope of practice, particularly in MDTs. Additional curricula may be required to support practitioner awareness and interprofessional supervision of working to full scope or expanded scope of practice.

Funding mechanisms

- *Simplified time-based item numbers to incentivise GPs working to full scope of practice.* Ambiguous MBS descriptors and poor or restrictive rebates are a disincentive for GPs to take on home visits or longer consultations like palliative care and mental health consults. Time-based item numbers should be simplified to recognise that many patients don't present with easily compartmentalised or cookie cutter healthcare needs.
- *Expanding MRI rebate descriptors for GPs*. GPs are often faced with either referring to a non-GP specialist so that the patient gets a rebatable MRI or passing the cost on to the patient. Expanding the MRI rebate descriptors for GPs would allow the practitioner to work to their full scope of practice and provide more efficient patient care.
- *Timely access to affordable investigations*. Patients in the process of being appropriately investigated by a GP often present at emergency departments as imaging or pathology is perceived as more accessible and cheaper. Clarity and further investment are needed around the cost and availability of timely, affordable investigations to limit this duplication of care.
- *Broadening consultation items to support workforce flexibility and accountability.* Current MBS descriptors for consultation items discourage delegating and collaborating between primary care practitioners and working in MDTs as only the time spent by the GP is factored in the estimation of consultation time triggering payment. Including other team members in the consultation time would keep responsibility and accountability

within the team while allowing more flexible use of workforce. In turn, that would allow GPs to focus on more high needs patients while supporting other team members to also work at top of their scope.

- *Financially resource health practitioners to support communication, coordination, and continuity of care*. Currently health practitioners (e.g., pharmacists) are unable to bill under the MBS for their costs associated with reporting back to the GP about treatment provided to a patient. Financial infrastructure and resources are needed by other health practitioners to facilitate timely communication and coordination and ensure safe and high-quality continuity of care in GP-led MDTs.
- *Simplifying care plans and rebates for health practitioners in MDTs.* Under current MBS requirements a GP is required to produce and lodge a care plan via Medicare before other health practitioners to be involved in a patient's care can access Medicare rebates. Replacing the care plan system with a simple referral from the coordinating GP would be far more efficient and make it easier for all health practitioners in MDTs to work to their full scope of practice. Alternatively, the care plan process could be streamlined by either removing the requirement to get allied health feedback before finalising the team care arrangement (TCA) or allowing the TCA to be billed before hearing back, along with providing examples of how to complete care plans and TCAs.
- *Increase practice nurse incentives.* MBS item numbers for nurses working alongside doctors are few and recently the use of item 10997 (a very low sum) has been questioned when billed with chronic disease management documents. Nurses are a valuable part of any practice and MDT, but they are an expensive cost to practices. Increasing practice nurse incentives would make it easier for practices to employ nurses working to their full scope of practice.

Employer practices and work context

- *Clarifying professional indemnity in multidisciplinary team-based care.* In any MDT-based care, there needs to be a clear understanding about which member is accountable for what. Even when a GP is the coordinator or leader of the team, they will not have a view of what occurs in every episode of care provided by others in the team. In some cases, they will not even have expert knowledge in that area. GPs should not be exposed to the risk of civil claims or regulatory complaints purely because they lead any team where other health practitioners are applying their own expertise. There also needs to be a clear understanding about who will indemnify each party (each member of the team, and the practice they work in, particularly if they are independent contractors due to payroll tax arrangements).
- *Clarifying payroll tax implications in multidisciplinary team-based care*. The payroll tax situation facing GPs in several states and territories may act as a disincentive to increasing multidisciplinary team-based care. Currently, general practices are advised to engage GPs as independent contractors to minimise the payroll tax burden.
- *Removing multiple barriers in residential aged care facilities (RACFs).* GPs and other health practitioners face multiple barriers to practising at full scope in residential aged care facilities. There is high regulation, a high volume of faxes and paperwork, on call 24/7 in some areas, significant documentation requirements and very poor rebates/barriers to private billing. GPs also report a lack of communication and coordination between non-clinical managers and GPs around treatment decisions. For

example, non-clinical managers may question the use of certain drugs and will engage with non-GP specialists or dementia units, sometimes without collaborating with the GP. Non-clinical managers may report minor incidents such as minor bruises but not notify GPs of more significant events such as when their patient has died. One way to address these barriers to GPs working to full scope of practice in RACFs is to allow registered nurses in RACFs to make more clinical and triage decisions on an individual patient basis, while the GP is the coordinator of medical care.

- *Compliance and administration requirements on GPs.* There is a significant compliance and administrative burden (associated with compliance, privacy and legislative requirements) that is a barrier to GPs working to full scope of practice today. While these requirements are individually reasonable, together they add up in terms of time involved and time away from patient care. Examples include written assignment of benefit for Medicare bulkbilling and telehealth, medication checks using multiple state-based real-time prescription monitoring systems, individual medication approvals by phone, and MBS item management. The compliance and administrative burden on GPs needs to be more efficient so that more time can be spent helping patients.

Leadership and culture

- *Improving GP and patient understanding of appropriate full scope of practice*. GPs have the skills base and competency to carry out many tasks, but often more complex tasks are referred to other specialists either because they are perceived as offering better care or the GP thinks they risk being criticised if they don't. Patients sometimes also request a referral. Improving practitioner and patient understanding of the skills base of every GP and the tasks that a GP can safely do when working to their full scope of practice would prevent unnecessary referrals and improve efficiency in primary care. Task examples include (non-exhaustive):
    - Surgical – excision of skin cancers/lesions and small subcutaneous lesions, wedge resections for ingrown toenails
    - Psychiatry/psychology – uncomplicated mental health issues that GPs are well trained to manage
    - Gynaecology – insertion of IUD
    - Antenatal care – measurements
    - Skin checks
    - Uncomplicated fractures that only require plaster
    - Referral for endoscopy – GPs can manage the indications for, and the results of.

Q. What enablers can government, employers and regulators address to enable health practitioners to work to their full scope of practice? Please provide references and links to any literature or other evidence.

Through consultation with Avant's medical practitioner network and drawing on our own experience assisting and advising medical practitioners over many years, we have identified several enablers which could be addressed to enable GPs to work to their full scope of practice as GPs and in MDTs.

Legislation and regulation

- *Harmonised reform across Commonwealth and state and territory legislation, regulation, and programs to support safe, high-quality care*. We welcome steps to harmonise reform across Commonwealth and state and territory legislation, regulation, programs, and funding approaches to support health practitioners to work at full scope of practice. Reforms now underway to introduce a national licensing framework and safety and quality standards for facilities where cosmetic surgery is performed demonstrate how nationally consistent reforms can be coordinated and achieved across multiple jurisdictions to support safe, high-quality care (ACSQHC, 2023).
- *Consistent regulatory requirements for registered and unregistered health practitioners*. All health practitioners in the primary care sector should have clear accountabilities and be subject to the same regulatory requirements to enable safe, high-quality and targeted patient care with less duplication and fragmentation. This consistency should extend to new types of providers (e.g., physicians assistants and allied healthcare assistants).

Technology

- *Protocols can be impractical and prevent timely care*. We welcome steps to better incorporate and integrate technology such as decision support systems that can help more health practitioners to provide increased access to primary care. Agreed evidence-based clinical guidelines should be readily accessible, and it should be clear which ones are appropriate. However, it should be recognised that care provided by protocol is often impractical, particularly where patients present to primary care with a myriad of undifferentiated symptoms and signs.
- *Better system interoperability*. Improving the interoperability of software and medical records systems would make it easier and safer for health practitioners to work at full scope of practice by improving information sharing, reducing the administration required, and supporting better communication, coordination and continuity of care. This is particularly the case where several members of the treatment team are using different systems.

Education and training

- *Curricula to enable working to full scope of practice in primary care teams.* Differing views among health practitioners about the competence, skills or training required to perform tasks is a barrier to supporting health practitioners to work to full scope of practice, particularly in multidisciplinary teams. Additional curricula may be required to support practitioner awareness and interprofessional supervision of working to full scope or expanded scope of practice.

Employer practices and work context

- *Practice triage to stream consults by complexity to appropriately skilled practitioners.* Under the current model of care, where a patient makes an appointment and there is no triage, GPs often deal with very minor tasks (e.g., a repeat prescription, vaccination, referral for routine or screening investigations) when they could be doing more complex work. By introducing a triage system to stream consults by complexity, nurses working to their full scope of practice could deal with the minor tasks and refer to GPs as

appropriate and if given the right parameters. Equally, GPs working to their full scope of practice could manage more acute cases, e.g., uncomplicated fractures, sutures.

Leadership and culture

- *Improving GP and patient understanding of appropriate full scope of practice*. GPs have the skills base and competency to carry out many tasks, but often refer more complex tasks to other specialists. Improving practitioner and patient understanding of the skills base of every GP and the tasks that a GP can safely do when working to their full scope of practice would prevent unnecessary referrals and improve efficiency in primary care.
- *Improving GP leadership skills to enable team-based care.* Many primary care doctors aren't trained in management or leadership skills and, unlike hospital-based doctors and some other specialties and clinicians, generally don't work in a team-based model, except for administrative or low-level tasks. Investment in improving GP leadership skills will be essential to enable multidisciplinary team-based care.

References

Australian Commission on Safety and Quality in Health Care. Cosmetic Surgery Project (2023). https://www.safetyandquality.gov.au/standards/cosmetic-surgery-project

Additional views

Q. The broadest range of views will give the review a thorough foundation on which to consider new policy and regulation. Please share with the review any additional comments or suggestions in relation to scope of practice.

Avant is a mutual organisation, owned by its doctor members, and is Australia's largest medical indemnity insurer, providing professional indemnity insurance and legal advice and assistance to more than 85,000 healthcare practitioners and students around Australia. Over half of all Australian doctors are Avant members. Members come from all medical specialities and career stages, and every state and territory.

We assist members in civil litigation, professional conduct matters, coronial matters and a range of other matters. We have a Medico-legal Advisory Service that provides support and advice to members and insured medical practices when they encounter medico-legal issues. We also provide medico-legal education to our members with a view to improving patient care and reducing medico-legal risk.

Avant Mutual
16 October 2023